90-0688

Local No. 100878

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): EMMA WILLIAMS
2. SEX: FEMALE
3a. TIME OF DEATH: 12:10 P
3b. DATE OF DEATH (Month, Day, Year): JANAURY 31, 1990
4. SOCIAL SECURITY NUMBER: 311-26-4541
5a. AGE—Last Birthday (Years): 74
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Month, Day, Year): OCTOBER 4, 1915
7. BIRTHPLACE (City and State or Foreign Country): JACKSON, TENNESSEE
8a. WAS DECEDENT A U.S. VETERAN? NO
8c. YEAR LAST SERVED IN U.S. ARMED FORCES? --
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: GARY
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): CEPHUS WILLIAMS
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): UNITED FOOD
12b. KIND OF BUSINESS/INDUSTRY: CANTEEN-U.S. STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 625 W. 19TH AVENUE
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): BLACK
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): ELIJAH JONES
19. MOTHER'S NAME (First, Middle, Maiden Surname): MATALDA ESKEW

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CEPHUS WILLIAMS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 625 W. 19TH AVENUE GARY, IN. 46407
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 5, 1990-OAK HILL
21c. LOCATION—City or Town, State: GARY, INDIANA
22a. EMBALMER'S NAME: REV. DIANE E. WEEMS
22b. EMBALMER'S LICENSE NO.: 0-100-151-0
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Rev Diane E. Weems
24b. LICENSE NUMBER (of Licensee): 0-100-151-0
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: ANDREW SMITH FUNERAL HOME, INC. 934 E. 21ST. AVENUE-83002550 GARY, INDIANA 46407

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cerebral Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF)
b. Chronic Obstructive Pulmonary Disease
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

Approximate Interval Between Onset and Death

FILED

MAY 17 1990

Anna N. Anton

AUDITOR, LAKE COUNTY

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Alzheimers Disease, Parkinson's Disease

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): no

CERTIFIER

29a. CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.
☐ HEALTH OFFICER: On the basis of examination and/or investigation, in my opinion death occurred at the time, date, and place and due to the cause(s) as stated.
☐ CORONER: On the basis of examination and/or investigation, in my opinion death occurred at the time, date, and place and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: X Benj. [signature] F. Grant
29c. MEDICAL LICENSE NO.: 14878
29d. DATE SIGNED (Month, Day, Year): 2-3-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Benjamin F. Grant, M.D. 3195 Broadway, Gary, Indiana 46409

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): FEB 2 1990

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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SBH00-004 State Form 10110 (R2/3-89)

Rec # 46-513-12-Andrew Weems Rick Weems - E 37 FE - 4 - 13 13E1 13E1

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